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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

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CORRECTION OF PHYSICAL DEFECTS AMONG JUNIOR HIGH SCHOOL STUDENTS

RUTH R. BRONSON, M.S.

School Nurse, Los Angeles City Board of Education

The purpose of this study was twofold (1) to determine what percentage of corrections of physical defects advised by school physicians are made: (2) to evaluate the efficiency of present methods in effecting such corrections. More specifically, answers were sought to the following questions:

1. What percentage of corrections advised by school physicians are made?
2. What type of defect is most often corrected?
3. For what reasons do parents fail to follow the advice of school physicians?
4. Is the percentage of correction greater in homes of higher income than in lower income homes?
5. What type of notice of defect did the parent receive?
6. How long a period elapsed before action was taken?
7. What relationship, if any, is there between frequency of correction and each of the following:
   (a) sex
   (b) grade level
   (c) marital status of family
   (d) intelligence of the child
   (e) extent of the defect?

Present status of the problems of correction of physical defects. The studies which have been concerned with the examination of school-children have shown that there is no agreement upon what constitutes the ideal method of spacing or conducting such examinations. Controversy appears to exist regarding the best means of following through after the examination to secure correction of defects. Continual evaluations of present systems employed are in progress. At present no investigators have presented conclusive evidence that the most effective type and frequency of examination as well as the most productive means of stimulating correction of defects have been established.

Methods of procedure. The sample for this study included one hundred and fifty-five junior high school students (seventy-five girls, and eighty boys). For the most part they were from Mexican-American, "Anglo", Colored, Japanese, Chinese, and Jewish homes. The socio-economic level ranged from the lower bracket to the

Abstract of Thesis submitted to Immaculate Heart College, Los Angeles, California.

upper, with the largest number falling in the lower occupational levels. The IQ scores in the group varied from fifty to one hundred and ten.

The main sources of data were records of the health office and the counselor's office. These consisted of the student's office visit card, the health card, record of telephone calls, and the student's cumulative record. All physicians' recommendations, contacts with the student or the parent, visits of the student to the nurse's office, and all clinic reports as well as reports from private physicians were available in these records.

The socio-economic level was secured from the occupational level of the parent. Arbitrary weights were assigned to each level and those having a weight of 1, 2 and 3 were assigned to group one, as the lower income level. Those with a weight of 4, 5, 6 and 7 were classified as the middle level. Those having a weight of 8, 9, and 10 were categorized together as the upper level. These levels represented the theoretical upper, middle, and lower thirds.

The marital status of the family was determined by conference with the parents or from information in the cumulative record. A home was classified as either broken or normal, depending upon whether or not both parents lived with the child.

The intelligence of the child was determined by records of standardized tests administered at routine intervals during the student's life. All indices used were the result of group tests.

Extent and type of defect were secured from the physician's notes on the health card. This is a code system by which the physician indicates the degree of urgency by symbol of note.

The type of notice sent to the parent was secured from the physician's notes on the health card, and conference with the parent and student. Six categories were used: (1) verbal by student; (2) telephone by nurse; (3) home notice by the physician; (4) home call by nurse; (5) physician's conference with the parent at school; (6) nurse conference with the parent at school.

Information regarding the time elapse between notice of the defect and correction was obtained for the most part from the parent, clinic reports and letters from private physicians. When the time was established it was classified in one of five categories. These indicated whether or not steps were taken for correction in the first, second, third, fourth, or fifth month of the semester following the one in which the sample was taken. The students who were graduating at the end of the semester in which the sample was taken were followed up by means of special cards sent to the

nurse in the high school to which they went. This nurse made all future contacts and reported to the present investigator. The same items were investigated for this group and all others included in the sample.

The statistical procedures used were the *t*-ratio test, and chi square. Both procedures were used in testing the null hypothesis.

FINDINGS

I. *The influence of degree of severity.*

1. Analyses of the data indicated that sex may not be an important criterion in the correction of defects. There were more outstanding differences within sex groups than between them. There appears to be a tendency for ninth grade boys to correct mild degrees of defect more frequently than moderate or severe. This finding was consistently evident throughout the study.

2. There was a significantly higher percentage of severe defects corrected at the seventh and eighth grade levels while at the ninth grade level the correction of mild defects approached significance in the comparison with the correction of severe conditions, and was significant at the 1 per cent level when compared with the correction of moderate defects.

II. *The influence of type of defect.* Twelve types of defect were used in this section as categories into which were classified the two hundred and nine defects included in the study. These were: ear, dental, endocrine, nose and throat, heart, chest, orthopedic, visual, skin, surgical, nutritional, and medical. Analyses of the data relating to these classifications determined the following findings:

1. The defect most often corrected appeared to be ear defects. This group filled the requirements set by the study that the category so designated, in order to be meaningful, should have sufficient cases to find relationships, significant differences, or trends. Seventy-six per cent of those with ear defects corrected them. Visual defects were next most often corrected. Sixty-nine per cent of this group corrected them.

III. *Influence of intelligence in securing correction.*

1. Children whose intelligence quotient is 110 or above have fewer uncorrected defects. Significant differences were obtained in comparing this group with those having intelligence quotients between 100 and 109.

2. Pupils with intelligence quotients below 89 have significantly more defects uncorrected than those above that index. A

comparison of groups having intelligence quotients of 80-89 with those between 70-79, showed no significant difference. Similar comparisons between the 70-79 group with those between 60-69, and the 60-69 classification with those in the 50-59 intelligence quotient bracket showed no significance.

IV. *Influence of the marital status of the family.*

1. For the sample studied, marital status was not found to be a significant factor in the correction of defects.

2. The percentage of those from broken homes which corrected defects was 44 per cent, while those from normal homes who made corrections was 52 per cent. No significant difference was found between the two groups.

V. *Influence of the socio-economic level of the family.*

1. A significantly greater per cent of non-correction of defects occurs in lower economic levels. An extremely large *t*-ratio found in the comparison of the upper bracket with the lower points to the socio-economic factor as of great importance in the correction of defects.

2. Significance beyond the 1 per cent level was found in comparing the middle socio-economic level with the upper bracket. This difference in favor of the upper level was not as great as that found in the comparison of the upper and lower brackets.

3. No significant difference was shown in a comparison of the middle and lower socio-economic levels.

VI. *Reasons given by parents for non-correction.*

1. Reasons given by parents for non-correction fall into the following classifications: professional difference, financial, student objected, fear of poliomyelitis, lack of information, parent working and has no time, and parent procrastination.

2. Financial need accounts for the greatest per cent of failures to correct. Greater significance was found in favor of financial reasons in comparing this category with all other reasons for non-correction.

3. Parent procrastination is the second reason of importance in failure to correct defects. A comparison of this category with the financial reasons group yielded a *t*-ratio of significance in favor of the financial needs group. Since this difference was at the 5 per cent level it appears that the two categories are not as dissimilar as are the other classifications.

VII. *Influence of type of notice to parent.*

1. Of the six methods used in this study of notification to the parent of a defect, the telephone call by the nurse and the home

call by the nurse do not seem to be significantly different. In the comparisons with other methods both were found to be important in effecting correction of defects. In comparing the two categories no significance was demonstrated. Other methods used were the verbal message by the student, the nurse's conference with the parent at school, the physician's conference with the parent at school, and the physician's written home notice.

2. The conference by the school physician and the conference at school by the school nurse are of equal importance in securing correction. However, because of the few cases analyzed no conclusion could be drawn. Since the purpose of this study was to find an effective means of obtaining correction while conserving the physician's time this inadequacy of data is not important to the study.

3. The written home notice by the doctor and the verbal message carried by the student are of lesser value in number of defects corrected. Comparison of the two methods showed no significant difference.

VIII. *Elapsed time between notice and correction.*

1. Most of the defects were corrected early if correction was to be made. Fifty-nine per cent of the cases made correction in the first month of the semester following notification of the defect to the parent.

2. The rate of correction dropped sharply after the first period. This was true following all types of home notice used in the study. As more time elapsed the general tendency was to make fewer corrections.

CONCLUSIONS

The following conclusions appear to be justified on the basis of the data presented:

1. Sex in itself was not an important factor in the correction of defects. The tendency of ninth grade boys especially to correct mild defects may be indicative of the development of some interest which may be thwarted by that special degree of disability. It is possible that this may be due to the development of social consciousness.

2. Intelligence is an important factor in securing correction of a defect. Those whose intelligence quotient was over 110 had less uncorrected defects. Those below 89 had significantly more defects uncorrected. The intelligence quotient of 89 seemed to be indicated as a critical point. Therefore, this particular index assumed outstanding importance in the present study.

3. Marital status of the family was not a significant factor in the correction of defects. It is possible that those defects which were not corrected in homes classified as broken may have been due to other factors such as intelligence or socio-economic level.

4. Socio-economic level is important in securing correction of defects. Those in the lower socio-economic levels have a significantly higher per cent of non-corrected defects.

5. Financial need was of importance in obtaining correction of defects. This conclusion is closely related to the preceding one in regard to the socio-economic levels. Further emphasis is given to this conclusion by the statement made in a report of subcommittee of Federal Governmental Agencies[1] that financial ability definitely influences ability to secure medical care.

6. Parent procrastination was an important factor in the non-correction of defects. With sources available to the child for correction of a defect, the delay of a parent in requesting such care was the only obstacle in the way of correction in a large per cent of the cases followed in this investigation.

7. As a means of notifying the parent of a defect the telephone call by the nurse and the nurse's home visit are important. The home notice to the parent by means of a physician's written home notice and by verbal notice carried by the student were of lesser value.

8. If defects were corrected this was accomplished usually soon after the notice to the parent that such a defect existed and correction recommended.

RECOMMENDATIONS

The problem of the correction of physical defects on the recommendation of the school physician obviously is one which is affected by many factors. The present study has presented findings drawn from data compiled within the scope of the investigation. In view of the conclusions formulated from these data, the following recommendations are made:

1. That the correction of defects might be encouraged by the development of a health educational program based upon social consciousness, since the data throughout indicated that when the social factor was involved even mild defects were corrected. This is particularly true at ninth grade level where, according to other research, social consciousness is developing.

2. That special emphasis be placed upon parent and student education in the need for correction of defects in the case of children whose intelligence is found to be 89 or below. As shown by the data, those in that category had more uncorrected defects than did those above this point.

3. That efforts to secure correction of defects be directed toward those in the middle and lower socio-economic levels rather than those in the upper bracket, since the largest percentage of uncorrected defects was found in these levels.

4. That a comprehensive educational program be undertaken for the purpose of acquainting parents with the community resources available in order to overcome the effects of financial need and parent procrastination. This recommendation is made because these two factors were found to be the most frequent reasons given by parents for non-correction.

5. That more use be made of the telephone as a means of notifying parents of the school physician's recommendations since the data indicated this method to be more effective than the other means of communication with the home in securing parent cooperation. It also would be a means of conserving time.

6. That frequent home notification be made in the case of uncorrected defects in order to keep the physician's recommendation fresh and clear in the mind of both parent and student. This recommendation is based upon the finding that the greater percentage of corrections were made soon after the parent received notification of the defect.

1 "Health Needs of School-Age Children, and Recommendations for Implementation," School Life, 28:7-15, November, 1945.

WHY DO ROUTINE URINE ANALYSIS OF SCHOOL CHILDREN?

RUTH H. WEAVER, M.D., M.P.H., *Director*
GRACE D. LOFTHOUSE, R.N., B.S., *Nurse Coordinator*
Division of Medical Services, Board of Public Education, Philadelphia, Pennsylvania

Routine urine analysis is not a part of the school health examination of pupils. However, in March, 1947, at the request of several physicians from the Philadelphia Metabolic Association, the Division of Medical Services of the School District of Philadelphia began a program of urine testing of selected groups of pupils by means of screening for sugar and protein. At that time an average of about 134 pupils per year were known to have diabetes. This number has been increasing in proportion to the general increase in pupil population.

It was possible, however, that there might be some unknown cases of diabetes. Because children, unlike adults, tend to develop diabetes abruptly, and because their symptoms are acute and are recognized promptly, it was felt that a few incipient or unsuspected cases would be discovered. Nevertheless, it seemed worthwhile to explore the value of this approach.

In 1950 a report of the Detection Drive in Dayton, Ohio, disclosed 18 previously unknown diabetics among 38,500 children tested.[1]

Dr. Yankauer in the A.P.H.A. Journal of April, 1951, in his report of further evaluation of the Astoria Plan of School Medical Services in New York City elementary schools, concluded from studies of physical examination and screening tests on 334 children in underprivileged slum areas, that urinalysis was not of value in case finding.[2]

Because the beginning of the Philadelphia study antedated these reports, it was continued to see what urinalysis screening would reveal here. Pennsylvania state law requires a complete physical examination of pupils. Urine checks were made on pupils in selected age groups about the time of their physical examinations. Urine specimens were collected in the schools in order to avoid contamination. All age groups were sampled. Both boys and girls were included, as were all the major nationality backgrounds. The program was begun in 1947 and continued through 1953, with the exception of the school year 1948-1949 when (due to post-war shortages) not all the necessary equipment was obtainable.

From year to year changes and adjustments were made in the testing techniques and procedures as recommended by our advisory

Method used in Testing Urine Samples

physicians. In the interest of accurate reporting, therefore, it is better to consider the entire program in relation to its several separate projects or units.

In Project I, spring term 1947, the urines of 2045 pupils in grades 1 and 3 were tested. Dr. Wm. P. Belk, pathologist of the Episcopal Hospital, had suggested the Cargille reagent for protein and both Clinitest and Galatest for sugar. The school nurses were trained to do the screening. Urines found positive by them were re-checked by the laboratory in the Central Office of the Division of Medical Services. If positives were found by the laboratory, using Fehling's Solution and/or heat, a second specimen was sent to the laboratory. Final positives were reported back to the school nurses for follow-up. This consisted of contacting the parents and urging them to seek medical care for the child. Reporting of results to the Division of Medical Services required a statement as to the nationality background of pupils, and of any history of known diabetes in their families.

A total of 98 urine specimens were sent to the laboratory, 21 suspicious by Clinitest, 14 by Galatest, 52 by Cargille; 11 were sent because of cloudiness. Of these 98, 46 were found positive for protein and 2 for sugar. A second check left 27 positive for protein and 1 for sugar. The positive sugar was found in a third grade native white girl. She was hospitalized immediately at Temple

University Hospital, where she remained for three weeks. She was diagnosed as having true diabetes mellitus, and was placed on insulin therapy. There was no history of diabetes in her family, but she had had an abscessed jaw five months previously, and had lost 10 pounds in the preceding year. Reports of treating agency diagnoses on positive proteins of Project I will be found summarized with those of the two succeeding projects conducted in the same school year.

After this first testing, Dr. Irving J. Wolman, pediatrician of the Children's Hospital of Philadelphia, suggested the following modifications of techniques.

1. Use Clinitest alone for sugar, since it seemed to be so much more clearly positive or negative to the nurses than Galatest.
2. Use the same specimen or both Clinitest and Cargille in order to save time and to facilitate the testing process generally.
3. Add a microscopic examination of the urines with positive proteins so that faint traces of protein with no positive microscopic findings could be ignored, thus eliminating diagnoses by treating agency of "No significant pathology", as happened in Project I.
4. Examine a repeat specimen for protein collected on a fasting basis.
5. Examine a repeat sugar specimen collected 2 hours p.c.
6. Notify the parents only after three separate positive findings are obtained by the laboratory.

Project II was started on the basis of these modifications in the spring of 1948. A total of 2,922 checks was done on urines of 1,407 boys and 1,515 girls about evenly divided between the 5th and 7th grades. Final positives here were 0 for sugar, and 22 for protein.

Using the same testing techniques, but stressing the health education aspects of urinalysis to a greater extent, Project III was launched and finished in the same school year, 1947-1948. In this, the testing was done on 2,000 pupils in three junior high and two senior high schools. Of these, 18 were finally positive for protein and 0 for sugar.

In Projects I to III inclusive, persistent efforts were made by the school nurses to get each pupil with a positive test under medical care, and to obtain reports from the treating agencies. They were successful in securing these results in 39 of the 68 positives. The 1 positive sugar was reported in Project I.

Following is a table of treating agency reports regarding positive proteins.

TREATING AGENCY REPORTS ON POSITIVE PROTEINS

Findings	Age Group			Total
	6 - 9	10 - 13	14 - 17	
Negative	13	5	0	18
Benign albuminuria	2	1	8	11
Pyelitis	0	2	0	2
Pyelonephritis and nephrosis	0	1	0	1
Albuminuria associated with infection	3	3	0	6
Glomerulonephritis	0	0	0	1
TOTAL	18	12	8	39

Project IV was conducted in the school year 1949-1950. 5049 urines were tested for sugar only. One was found to be positive, and on follow-up had an elevated blood sugar. This was a high school boy diagnosed as a mild diabetic, and controlled by diet alone. His father was a mild diabetic, and his paternal grandfather had had a bilateral leg amputation as a result of diabetes.

At the end of the fourth year of urine testing, records showed no correlation between positive findings and history of diabetes in the family, or nationality background, so these items were eliminated from the required report at that time.

KNOWN DIABETICS IN PHILADELPHIA PUBLIC SCHOOLS

School Year	Total Enrollment	Family Background				
		Italian	Jewish	Other White	Negro	Total
1950-1951	212,816	4	22	62	13	101
1951-1952	214,103	No Report				129
1952-1953	218,250	4	23	91	22	140
1953-1954	218,812	10	30	100	28	168

Project V in 1950-1951 screened 4951 urines of 4446 pupils in eight senior high schools, and 505 in one elementary school. (The latter was included because of principal and nurse concern regarding possible positive sugars in their pupils, in which there were a high percentage of Jewish children, many of whom were overweight.) Laboratory reports here showed 174 positive proteins and 9 positive sugars. Treating agency reports reduced the positive sugars to two. Both of these proved to be non-diabetics. One was a senior high school boy who had a low kidney threshold for sugar. The other was an elementary school boy, whose family seemed to run urine sugar not caused by diabetes mellitus.

Nearly all of the pupils with positive proteins were diagnosed by a treating agency as having conditions other than kidney pathology.

At the end of the school year 1950-1951, it was decided to offer blood sugar evaluation in our laboratory to pupils with positive sugar in the urine, and to refer for medical care only those pupils whose findings were positive in this test.

Project VI was conducted in 1951-1952. Tests were made on 3845 pupils, 2017 in five elementary schools, and 1828 in three senior high schools. Of these, only 3 urines were finally positive for protein and 1 for sugar, but this pupil had a negative blood sugar.

Project VII was conducted in 1952-1953 in two schools only—one the elementary school mentioned above, and the other a senior high school in which the principal was especially interested. Of 755 pupils screened, 255 in the senior high and 500 in the elementary school, there were 3 positive for protein and 3 positive for sugar, one of which was a known diabetic, one had a low kidney threshold, and the third, a high school pupil, was found to be an unsuspected case of diabetes diagnosed at the Northern Division of the Einstein Medical Center and controlled by diet alone.

Project VIII in 1953-1954, the final screening, gave no positives for either protein or sugar in the 569 tested.

Summary and Conclusions: A total of 22,136 urines of pupils were screened. Of these 247 were found positive in our laboratory for protein and 15 for sugar. Of the positive proteins an overwhelming majority were found later by treating agencies to be either negative, benign, or of little serious significance. Of the positive urine sugars, all but 4 were later found to be due either to low kidney thresholds or causes other than diabetes mellitus. Only 3 newly discovered cases of diabetes were found in these studies, one an elementary pupil, and two from secondary schools.

As a result, we are in entire agreement with Dr. Edward R. Schlesinger in his statement in HEALTH SERVICES FOR THE CHILD that "the value of routine testing of urine for screening purposes (in children) is questionable. The presence of albumin is more often than not finally diagnosed as orthostatic albuminuria, so that the discovery of many children with benign conditions leads to needless apprehension until the nature of the condition is settled."[3]

Perhaps of even greater significance to school health programs in relation to their physical examination timing is the following observation by Dr. Schlesinger: "Juvenile diabetes and rheumatic fever are most readily found by the prompt examination of children who show deviations from good health, especially when the changes have been noted to follow infection."[3]

While urine analysis is valuable as an integral part of a complete physical examination in a private office or clinic, it does not seem to be justified in a school health examination. The chief advantage of urine analysis in the school system may well be its health education value. Perhaps a systematic effort should be made to have pupils receive an examination of urine for their last physical examination in school, in order to emphasize the need for this test as a routine part of all later physical examinations they may have.

URINE TESTING FOR PROTEIN ANR SUGAR
(As verified by Laboratory of Board of Education)

School Year	Project Number	Total School Enrollment	Urine Analyses Done	Final Protein	Positive Sugar	Elevated Blood Sugar	Diabetes Previously Unsuspected
1947-48	I, II, III	210,645	6967	67	1	1	1
*							
1949-50	IV	213,001	5049	Not tested	1	1	1
1950-51	V	212,816	4951	174	9	0	0
1952-52	VI	214,103	3845	3	1	0	0
1952-53	VII	218,250	755	3	3	2	1
1953-54	VIII	218,812	569	0	0	0	0
Totals			22,136**	247	15	4	3

* 1948-49 No tests conducted—shortage of materials.
** A total of 17,087 urines were tested for protein.

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3. HEALTH SERVICES FOR THE CHILD, Edward R. Schlesinger, M.D., M.P.H., McGraw Hill Book Co., Inc. 1953.

* * *

COMMUNITY CARE FOR HANDICAPPED CHILDREN

The American Public Health Association has available for distribution four basic guides to methods of Community Care for Handicapped Children. These basic reference manuals represent six years of work and represent the collaboration and endorsement of many organizations including our own association. They are:

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—A. V. DeWeere, M.D.

PLANNING FOR A STATEWIDE SCHOOL ADMINISTRATORS CONFERENCE

"Functional School Health Program"

ANNETTE L. EVELETH, R.N., M.S.
Director, School Health Services
Department of Education, State of New Hampshire
Concord, New Hampshire

The annual New Hampshire State Department of Education conference for school administrators held at Plymouth Teachers College, Plymouth, New Hampshire, on June 22-24, 1955, brought together some 250 superintendents, principals and helping teachers to study a functional health program for the public schools. This conference, dealing with school health, was called by Dr. Austin J. McCaffrey, Commissioner of Education, upon request of interested school administrators.

The plans for the conference were directed by Commissioner McCaffrey with assistance on details and arrangements by a committee including the Chief of the Division of Administration and the Director of School Health Services of the State Department of Education, and four school superintendents, who had previously attended the New England Administrators Conference on School Health at Williamstown, Massachusetts, in 1953.

The interest areas included in the conference theme, "A Functional School Health Program," were:

1. Providing a healthful environment
2. Approaches to health education in the classroom
3. Providing adequate health services

At the pre-conference planning meetings, five school superintendents were selected by the committee to be leaders for the five discussion groups on "Healthful Environment" and five elementary and/or secondary school principals for the sectional discussions on "Providing Adequate Health Services." Each group leader was asked to appoint his own recorder.

Following two general meetings in the specific interest areas, the administrators reported to one of five discussion groups. To have a fairly even distribution of people at the group meetings the members were asked to attend the group, the number of which corresponded to a number on their registration receipt.

One meeting was held for the leaders prior to the date of the conference to help plan their meetings and to select their consultants from a previously prepared list. The interest area of the consultant guided the group leader's thinking and preparation for

his group discussion. This preliminary organization eliminated the need of taking precious time after the discussion groups had assembled.

The selection of the consultant was based on the needs. The following examples illustrate the procedure—

A. Healthful Environment
   State
      District Sanitarian, School Building Specialist
   Local
      Superintendent of Buildings and Grounds, Safety Patrol Director, City Health Officer
B. Health Education
   State
      Teachers College Instructors, Director of School Lunch Program
   Local
      Secondary School Teacher, Elementary School Teacher, School Nurse-Teacher
C. School Health Services
   State
      Dental Services, Crippled Children's Program, Child Guidance Clinic
   Local
      School Physician, School Nurse-Teacher

The whole group met before the conference to discuss "Approaches to Health Education." Group dynamics stimulated the thinking from the floor, with a panel of resource persons available to answer questions or to contribute to the discussions of the administrators.

The conference coordinator, Dr. John A. Holden, Jr., Commissioner of Education, State Department of Education, Montpelier, Vermont, opened the conference with suggestions on "How a Conference Can Make a Contribution to Health Education." Dr. Holden was present at all general meetings, visited discussion groups, reviewed the reports of the recorders and closed the conference with a summary of the thinking which had developed during the past two days.

Dr. Holger F. Kilander of the School of Education, New York University, one of the guest speakers, highlighted several stages of development in a good school health program during the past twenty-five years.

Dr. Alice Donnelly, professor of health education, Danbury State Teachers College, Danbury, Connecticut, conducted the program, "Approaches to Health Education in the Classroom."

Mrs. Josephine McFarland, former supervisor of school nurse-teachers, New York State Department of Education discussed "The School Nurse-Teacher — A Spinning Top," prior to the group meetings on the health services programs for our schools.

Mrs. Mary Jones, school nurse-teacher, Laconia High School,

told how she helped students in the secondary school health program.

The exhibitors brought in materials with emphasis on this area of health. A display was set up to show how one of the rural communities conducts its health appraisal program through community interest of volunteers and the use of the local hospital. Books, literature and resource materials were made available for the school administrators to review or to take with them for future reference.

A report of the conference highlights will be sent to all school administrators and special groups interested in the area of school health.

The effect such a conference will have in our schools cannot be wholly evaluated at this time. The spirited discussions indicated the school administrators' interest in knowledge concerning improved healthful environment, more unified education and better school health services. A few local or regional school health workshops are being planned for school personnel in the fall.

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REVIEW

Airborne Contagion and Air Hygiene. *William Firth Wells,* Commonwealth Fund by Harvard University Press, pp. 423. Price $6.00.

Covering the general area regarding contagion, the problems falling within the title are presented and discussed. The first Section covers the theory and discussion of Airborne Contagion, — The second Section deals with air hygiene—various studies and analyses of airborne infections, dealing largely with droplet infection.

This is a text of great value to the health student and to the health officer who wishes definite information concerning the formation and spread of airborne infection.—*Charles H. Keene.*

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NEWS AND NOTES

The Spring, 1955, *Bulletin of the International Union for Health Education of the Public* contains an item titled, "Getting to Know our Members," which gives a short history, statement of functions and analysis of the spread of membership of the American School Health Association. Dr. Clair Turner is President of the International Union, which lists among its objectives the encouragement of international cooperation among health educators, and the further extension of health education throughout the world. The Third Conference of this association will be held in Rome, Italy, from April 27 to May 5, 1956.

EFFECT ON ORAL CLEANLINESS PRODUCED BY DENTAL HEALTH INSTRUCTION AND BRUSHING THE TEETH IN THE CLASS ROOM

The 1953-1954 Baltimore Tooth Brushing Study

H. BERTON MCCAULEY, D.D.S.[1], LILLIAN B. DAVIS, SC.D.[2] AND TODD M. FRAZIER, A.B.[3]

Early in the 1953-1954 school year the Division of Health and Physical Education of the Department of Education and the Bureau of Dental Care of the Baltimore City Health Department embarked on an experiment in health education, referred to in this report as the 1953-1954 Baltimore Tooth Brushing Study. Its prime purpose was to determine whether a short course of instruction in dental health, including brushing the teeth in the class room, produced any measurable effect on the cleanliness of the teeth of upper elementary-grade children in the Baltimore Public Schools.

Subjects. The study involved two groups of children, predominantly of the fifth grade. One contained 491 boys and girls in thirteen schools who received a month-long course of instruction in dental health, including a series of practice periods during which they brushed their teeth in the class room, using a drill procedure. The other group, intended to serve as a control, consisted of 283 boys and girls in eight schools who were given no instruction in dental health or tooth brushing. Both groups were representative of the whole public school population insofar as it was possible to select for participation in the study schools serving children of similarly varying socio-economic and racial background.

Instruction. The teaching was designed to motivate good general dental health practices and establish the habit of brushing the teeth correctly. It included the fundamental principles of care of the teeth, good grooming, tooth function, tooth decay, diet, the how and why of tooth brushing and the role of the dentist. These principles were developed with the children in discussions and varied activities which required 15 to 20 minutes a day for twenty school days. Charts and other printed material, at the discretion of the teacher, were used as aids.

During the second week of the project the children participated each day in an organized tooth brushing drill conducted immediately after the opening activities or following the lunch period. At this time the teeth were actually cleaned in the class room, using a simple vertical-stroke technique readily adapted to drill procedure.

1. Director of the Bureau of Dental Care, Baltimore Health Department. 2. Supervisor of Health Education, Baltimore City Public Schools. 3. Director of the Bureau of Riostatistics, Baltimore City Health Department.

At the close of the second week of the course the children took tooth brush and dentifrice home and began a daily record of their use. Class room activities were continued for two more weeks and culminated with a class room play or other special project featuring dental health. Teachers were requested to discontinue instruction and refrain from all but casual reference to tooth brushing after the close of the four-week period. Parents were not asked to participate in the instruction, nor were they or the children notified in advance that the course would be given.

Inspection. All the children in both groups received an inspection by a dentist (the same in each instance) to determine the status of oral cleanliness on four separate occasions: (1) immediately preceding the course of instruction, (2) at the close of the course, (3) one month after the close of the course, and (4) shortly before the close of the school year. Children who did not receive instruction were inspected concurrently with those who did. Inspections were made without advance notice to the children, particularly the initial inspection. Many children suspected that subsequent inspections would be made but did not know when.

Each child, on inspection, received an oral hygiene score which numerically expressed the relative cleanliness of the teeth and mouth. This score was derived from an estimation of the cleanliness of the six upper anterior teeth using simple criteria for the assignment of a number to each.[1] The individual tooth was scored from 1 to 4, the highest representing a maximum state of cleanliness. The oral hygiene score for the child was the sum of the individual tooth scores divided by the number of upper anterior teeth present.

Inspections were done in two waves, the first beginning in September 1953 and the second in February 1954. The division of instructed and uninstructed children into these waves is indicated in the tabulated results. The intervals between inspections in both waves were the same except in the instance of that between the third and fourth inspection. In the first wave the final inspection followed the third by four months. In the second wave this interval was two months.

RESULTS

The effect on the cleanliness of the mouth produced by the dental health instruction, tooth brushing drills and repeated inspections of the teeth by a dentist is reflected in differences in oral

1. King, R. N. Journal of Dental Research 30:399, June 1951.

hygiene scores between the first and subsequent inspections. For example, as tabulated, the

Average change in score at any given inspection	=	Average score at that inspection	—	Average score at the first inspection

In this way all children and groups of children serve as their own control and improvement or regression is measured from the level at which the children entered the experiment. Accordingly, the table gives the average initial oral hygiene score and the changes in that score observed at the second, third and final inspections for each class room of children in the study, considering, however, only children present for observation at all four inspections. Average changes of score for all instructed and uninstructed children in each wave of inspections are plotted in Figure 1. The percentages of children in the same groups who had attained the maximum oral hygiene score at each inspection are plotted in Figure 2.

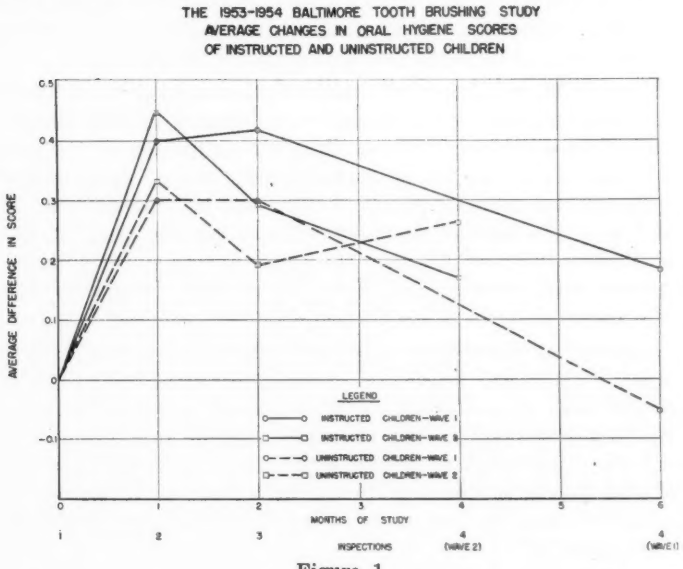

Figure 1

Discussion. Instructed and uninstructed children showed some improvement in the cleanliness of the mouth one month after the initial inspection. This improvement, apparently greater among the instructed than the uninstructed, gradually diminished after the second or the third inspection, but two to five months later

both groups continued to retain an average of about one-half the gain observed at the end of the first month.

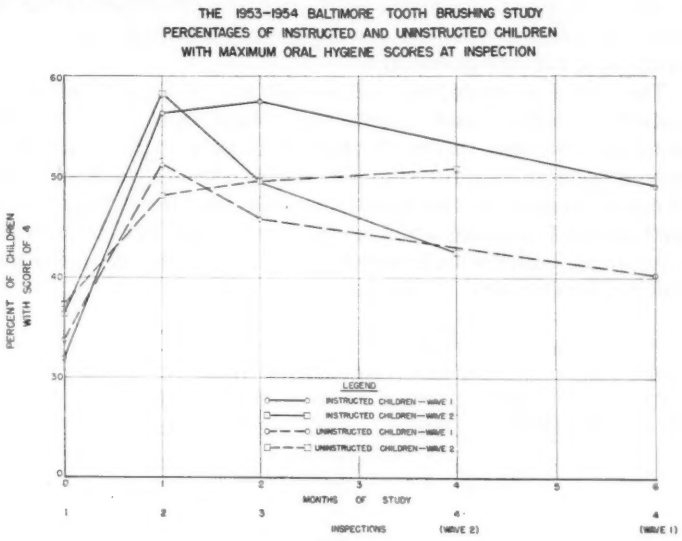
THE 1953-1954 BALTIMORE TOOTH BRUSHING STUDY
PERCENTAGES OF INSTRUCTED AND UNINSTRUCTED CHILDREN
WITH MAXIMUM ORAL HYGIENE SCORES AT INSPECTION
PERCENT OF CHILDREN WITH SCORE OF 4
60
50
40
30
0
LEGEND
INSTRUCTED CHILDREN — WAVE 1
INSTRUCTED CHILDREN — WAVE 2
UNINSTRUCTED CHILDREN — WAVE 1
UNINSTRUCTED CHILDREN — WAVE 2
0 1 2 3 4 5 6
MONTHS OF STUDY
1 2 3 4 4
INSPECTIONS (WAVE 2) (WAVE 1)

Figure 2

Differences in oral cleanliness between instructed and uninstructed groups were less evident among children observed in the second than in the first wave of inspections. Final inspections in the second wave, made four months after the initial inspection, showed that the oral cleanliness of uninstructed children compared favorably with that of the instructed group. Subject to the restriction that uninstructed children received from their teachers no particular encouragement or unusual experience emphasizing the teeth or their health, there is reason to presume that inspections of the teeth by a dentist had the effect of increasing personal attention to the teeth and the condition of the mouth. However, it was learned that many ostensibly uninstructed children in the second wave, notably in Schools 22, 143 and 214, had received some motivation and instruction.

Summary. Upper elementary-grade children, given a four-weeks course of instruction in dental health that included brushing the teeth in the class room, exhibited an improved general state of dental and oral cleanliness over a period up to five months after the close of instruction. Similarly aged children whose teeth were inspected concurrently by a dentist, but who did not receive dental

health instruction, also showed improvement, but of a somewhat lesser order. Gains in oral cleanliness realized through instruction and repeated inspections diminished gradually after instruction was discontinued and the inspections apparently assumed some characteristics of a routine procedure.

The authors gratefully acknowledge the helpful efforts of principals, teachers and pupils who made this study possible. Thanks are due also to Dr. C. Alfred Shreeve of the staff of the Bureau of Dental Care for aiding in the inspections, to Miss Marion P. Morris, director of the Educational Service Department of the Bristol-Myers Company, and her successor, Miss Ida B. Crawford, for supplying health educational material and assisting in the tabulation and development of the data.

The 1953-1954 Baltimore Tooth Brushing Study
CHANGES IN AVERAGE DENTAL HYGIENE SCORES

School	Grade	Number of Children	Socio-Economic Level	Average Initial Score	Change at 2nd Inspection	Change at 3rd Inspection	Change at 4th Inspection
Instructed Children—First Wave							
20	6B	23	L	2.7	0.8	0.9	0.5
50	5	27	A	3.2	0.3	0.6	0.1
53	5	25	A	3.2	0.1	0.0	—0.2
64	5	30	H	3.2	0.3	0.1	0.1
141	6B	33	N	2.7	0.7	0.7	0.6
211	5	31	A	3.2	0.3	0.1	0.1
The Group		169		3.03	0.40	0.42	0.18
Instructed Children—Second Wave							
10A	5	13	L	2.9	0.1	0.0	—0.1
	5	18	L	2.7	0.6	0.3	0.4
34	5	25	L	3.2	0.3	0.0	0.0
	5	21	L	2.4	0.5	0.0	0.2
83	5	21	A	3.1	0.3	0.2	0.0
	5	29	A	2.7	0.2	0.2	0.2
135	5	26	N	2.7	0.8	0.6	0.2
	5	24	N	2.9	0.7	0.7	0.3
146	5	21	N	2.4	0.5	0.3	0.2
	5	27	N	3.0	0.5	0.2	0.2
213	5	28	H	3.4	0.3	0.3	—0.1
	5	26	H	3.1	0.5	0.2	0.2
223	5	25	H	3.0	0.5	0.6	0.3
	5	18	H	3.3	0.5	0.4	0.4
The Group		322		2.92	0.45	0.29	0.17
Uninstructed Children—First Wave							
53	5	12	A	3.2	—0.1	0.1	—0.6
64	5	18	H	3.4	—0.1	0.0	—0.2
141	6B	31	N	2.6	1.0	1.0	0.6
211	5	31	A	3.1	0.4	0.1	0.0
The Group		92		3.02	0.30	0.30	—0.05
Uninstructed Children—Second Wave							
22	6B	26	L	2.8	1.1	0.2	0.3
85	5	24	A	3.3	—0.1	0.0	—0.2
	4A	22	A	3.1	0.1	0.0	—0.1
143	5	34	N	2.9	0.4	0.2	0.3
	5	23	N	2.6	0.5	0.7	0.6
214	5	38	H	3.0	0.0	0.0	0.0
	5	24	H	3.1	0.3	0.2	0.5
The Group		191		2.98	0.33	0.19	0.26
All Children—Combined Waves							
Instructed		491		2.95	0.43	0.33	0.17
Uninstructed		283		2.99	0.32	0.22	0.16

* L—Low A—Average H—High N—Non-white

BOOK REVIEW

The Human Body — *by Cyril Bibby and Ian T. Morrison,* Puffin Picture Book No. 102, Penguin Books, Inc., Baltimore. Publication Date September 16, 1955.

During the last fifty years publishing houses have met their share of the responsibility of providing intelligent health and sex education for school children, a recurrent, if not perennial, pedagogic problem of each generation, by periodically bringing into print new and improved series of books and tracts of wide variety dealing with this most vital subject. Generally speaking, these publications have fallen into two classifications, namely, books written for direct reading by the children themselves, and books written more expressly for parents and teachers to serve as guides in their home and school room health and sex education instruction. Although originally most of the authors of such texts were physicians or clergymen, the trend in recent years has been for such books to be written more and more by professional educators, those worthy citizens on whose laps, rightly or wrongly, parents have come to place an increasingly large portion of the responsibility for children's health and sex education.

When one reviews the older books and tracts on health and sex education for school children, two general observations and criticisms have been recognized. *First,* the factual material in such texts too often was expressed in somewhat ambiguous and stilted vocabulary, and not infrequently the authors (whether for reasons of literary modesty, or "what have you") dodged specific discussion of the critical facts about the body and sex which should not have been avoided. *Secondy,* and an equally important criticism, the illustrations employed in the older texts too often were poorly done (usually in unattractive black and white) and quite commonly they were so sketchy and vague that the textual material did not receive adequate supplemental elucidation. The net result was, or has been, that many children found the older texts dull and perplexing or befuddling reading, while their parents and teachers did not find the texts particularly helpful adjuncts in trying to teach their children about the essential physical and physiological facts of life.

It is the belief of this reviewer that the new Puffin Picture Book by Bibby and Morrison, THE HUMAN BODY, is perhaps the finest text of its sort which the reviewer has seen to date. The book has been written in such clarity and honesty of language, and

has been so admirably illustrated, that it evokes few or none of the criticisms levelled against the older texts in this field.

THE HUMAN BODY, first of all, should be a pleasure for children to read because of the simplicity and beauty of the language, and because of the clarity and honesty of the discussion. The choice and organization of material seems excellent. The discussion is written in children's language, and, being devoid of ambiguity, should be easy for them to understand. Most important of all perhaps, the authors have not skipped or avoided the so-called critical facts and functions of the body. There is no beating about the bush and doging hush-hush topics; basic questions are posed and explicitly answered. The choice of type is excellent, and youngsters should find the book easy to read without eye strain. The reviewer liked particularly the use of large letters in naming the anatomical parts in both the text and illustrations.

THE HUMAN BODY, secondly, should be a pleasure for children to read because of the first-class, beautiful colored and black and white illustrations. Most of these are diagrammatic, and evidence anatomical accuracy. The illustrations are clear, pertinent to the text, and certainly should attract the undivided interest and attention of children.

Not only should children find the book admirably suited to their desires and needs, but parents and teachers likewise should welcome the book for the excellent help it can give them in intelligent home and school instruction of youngsters about the way the human body is constructed and how it works. The book should not be considered a substitute for, but rather an adjunct to personal parental and teacher instruction.

—Floyd Boys, M.D., Univ. of Illinois.

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FEDERAL HEALTH FUNDS

Congress recently voted an increase of millions of dollars for research and expansion of services in the field of health. An evaluation of the entire field of mental health, and expansion of community mental health programs is proposed. Expansions in the fields of hospital construction, venereal disease control, expansion of services to crippled children and to those who are mentally retarded have also been ordered. Thirty million dollars were earmarked for polio vaccine in grants to states.

THE NATIONAL CONFERENCE ON PRIORITIES FOR NURSING SERVICES

NELL PETERSON

Supervisor of School Nurses, Sioux Falls, S. D.

A National Conference on Priorities for Nursing Services for the Child of School Age was held at the University of Minnesota Continuation Center, Minneapolis, Minnesota, October 17-21, 1955.

The conference was sponsored by the National League of Nursing, Department of Public Health Nursing. Fifty-two consultants in the fields of Education, Medicine and Public Health were invited to participate and serve as leaders in discussion groups.

Four discussion groups were assigned specific aspects of health services for school children. Each group held several sessions discussing the over-all function of the school nurse; specific responsibilities, ways in which the nurse contributes, factors that helps the nurse and factors that hinder.

Dr. Dorothy B. Nyswander, Professor, Public Health Education School of Public Health, University of California-Berkeley was Conference Director.

Three excellent papers were read in the general sessions. The Present Status of School Nursing by Agnes Fuller, Regional Consultant, Children's Bureau, Department of Health, Education and Welfare, New York. Where Do We Want to Go in the Future in Improving the Health of Children in This County by Dr. Alfred Yankauer, Director, Bureau of Maternal and Child Health, State Department of Health, Albany, New York. Health Learnings in Modern Educational System, Dr. Helen Starr, Health, Recreation, Physical Education, Minneapolis Public Schools.

In each general session time was given for the discussion of the papers presented and for the reports of the separate groups. Discussions at times were lively. Many changes were made in the reports and general thinking of the conference members — but in the final analysis we all went away with a feeling that much had been accomplished and that the general functions of the school nurse was clearly defined.

A report of the conference is now in the hands of the Editorial Committee and will be available in the spring from the office of the National League of Nursing.

MEETINGS

The American College Health Association held the Annual Convention at Colorado Springs, April 27-30. This is a companion organization of our Association dealing with student health on the college-level.

Their annual proceedings will be found in most college libraries and are a valuable reference for all school health personnel.

They now also have available for distribution the report of the Fourth National Conference on Health in Colleges. The purpose of this national conference was to bring together the best current ideas as to how the highest standards of health may be developed and maintained in colleges. Our association was one of the sponsors of the conference.

The report will be valuable to anyone interested in the health problems of our time. It may be obtained by writing Irvin W. Sanders, M.D., Ex. Secy. American College Health Association, Wayne University, Detroit, Michigan and enclosing $3.00.

A. O. DeWeese, M.D.

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Michigan School Health Association and Regional Conference of the American School Health Association — Held at Pantlind Hotel, Grand Rapids, Friday, May 20, 1955. Conference Theme WHAT ARE THE BLIND SPOTS IN YOUR SCHOOL VISION PROGRAM?

President—Cornelia Mulder
Vice-President—C. D. Barrett, Jr., M.D.
Secretary—G. Robert Koopman

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School Conference Considers Health Problems—Highland Park —The emergence of the medical profession, education, and public health as a functioning "team" was a major theme of the Fifth National Conference on Physicians and Schools, held here October 12-14.

More than 200 physicians, public health officials, educators, and representatives of related organizations participated in round-table discussions at the conference, sponsored biennually by the American Medical Association and its Bureau of Health Education. Thirty-four states and the District of Columbia were represented by the conferees.

REVIEWS

The School Health Sourcebook, *Oliver E. Byrd, Ed.D., M.D.*, Stanford University Press, and **Nutritional Sourcebook**, *Oliver E. Byrd, Ed.D., M.D.*, Standard University Press, Stanford, California.

These two texts really should be reviewed together: the subjects — parts of the School Health Program — are an integral part of our efforts to preserve and improve the health of children, although the Nutrition text is more inclusive than for the school age.

The procedure is collections of quotations from outstanding authors, summarization of articles appearing in scientific, medical, Health, and Educational Journals, digests of material from textbooks in the field, and citations of experiences.

Chapter IX of the School Health Sourcebook — on Communicable Disease Control — is particularly interesting and valuable.

The text on Nutrition includes opinions of, and studies of, such items as "Scurvy in Infants," Thumb and Finger Sucking in Infants; also in this Nutrition text are presented such topics as Chemicals in Foods, Food Infections and Restaurant Sanitation, and Nutrition in Industry.

These two texts are a careful, scientific and excellent piece of work. They present badly needed information in an interesting and easily usuable form. They are by far the most valuable and worthwhile sourcebooks in this field, since the — now thirty-year old — "Sourcebook in Health and Physical Education," by Thomas D. Wood, A.M., M.D., and Clifford L. Brownell, B.S., published by the Macmillan Company in 1925.

Each of these texts is a well of information, and should be a much used text in the library of professional workers in any phase of the School Health Program.—*Charles H. Keene.*

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Physical Education Syllabus. *James W. Long, Harold M. Barrow, and Marjorie Crisp.* Burgess Publishing Company, Minneapolis. pp. 168. Price $1.75.

In present times it is unusual for a Syllabus to be published as a private venture, although a generation or more ago this was common. So many states and cities now publish syllabi that non-public publications have been crowded out.

After thirty-five pages of preliminaries — such as Personal Health, Benefits, Posture, and Individual Exercise, and Measurement and Evaluation—the text presents in some detail the history and techniques of twenty-two games and sports ranging from Angling through the team games to Weight Training.

Line drawings of many activities and a Bibliography at the end of each section add greatly to the interest and value of this text.—*Charles H. Keene.*

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Handbook of Indoor Games and Stunts. *Darwin A. Hindman, Ph.D.,* Prentice Hall, 1955. pp. 304. Price $4.90.

Here is a practical text describing various types of games without wasting time on theories or philosophy.

The descriptions are divided into 19 classifications and these are grouped into "Quiet Games and Stunts," "Active Games, Contests, and Stunts," and "Puzzles and Problems;" making it easy for the instructor to find a game or stunt that fits the need.

A handy addition to the instructor's library.—*C. H. Keene.*

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RIDE 'EM SAFELY

Most accidents are due either to carelessness on the part of the rider or imperfect equipment. Parents can reduce the number of accidents caused by both of these. It's a good idea to check the family bicycles weekly for broken chains, loose handlebars and inefficient brakes, broken or burned out headlights, etc. Carelessness will reduce itself if children are taught the traffic rules and regulations. They should know as much about traffic rules as automobile owners.

Make sure your child knows the following basic rules for safe bicycle riding:

1. Obey all traffic signs and signals.
2. Always ride single file on the extreme right.
3. Never hitch onto other vehicles.
4. Stop to see that streets and sidewalks are clear before riding out of driveways or from behind parked cars.
5. Watch carefully for cross traffic at intersections; dismount and walk across heavily crowded thoroughfares.
6. Never ride another passenger on your bike; carry books or parcels only in a basket or carrier.—*Cleveland Division of Health.*

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